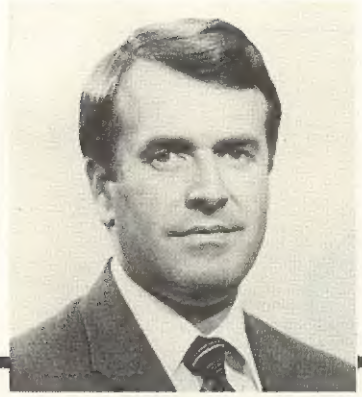

Public Health HIGHLIGHTS

by
Michael J Stapley, M.P.A.
Nancy Ann Chartier, R.N.

Hospice Movement in Utah

"All things have thier season and in their times all things pass under heaven. A time to be born and a time to die."

Ecclesiastes, 3:1

Hospice care for the terminally ill is becoming part of the mainstream of health care delivery.[1] It is a way of caring for the dying in a location of their choice, especially the home. Hospice unites the physiological support of skilled nursing care with the psychological support of emotional and spiritual comfort. Services are provided for those "patients who are diagnosed as terminally ill with a life expectancy of weeks or months."[2]

The hospice movement began in London, England in the 1960's, and moved to the United States in the 70's. Although there were less than 100 programs in the U.S. four years ago, there are now approximately 2,000 hospices located across the country. The first Utah hospice program began in 1977 in Salt Lake City as a volunteer home care program offering emotional and spiritual support to cancer patients and their families. With the assistance of funding from the United Way, Amercian Cancer Society and private donations, this volunteer program was able to expand its services to include skilled nursing care. Three types of hospices currently exist in Utah. Holy Cross Hospital has an inpatient unit which provides a full range of hospital services including psychological counseling. Hospice of Salt Lake, a community based program, provides skilled nurisng care as well as professional and volunteer psychological care. Thirdly, the remaining nine hospices are strictly volunteer programs which give emotional and spiritual comfort to the dying patient while a local home health agency supplies the skilled nursing care needed.

Although the structure of hospices varies, depending on the particular resources and needs of the community, each must include certain characteristics. They are:

1) On call availability, 24 hours per day, 7 days per week.
2) Designated Medical Director.
3) Provision for volunteer services.
4) Emphasis on patient and family as the focus of care.
5) Interdisciplinary team approach in providing care.
6) Emphasis on optimal pain control and comfort.
7) Means of providing staff support.
8) Provision for in-patient as well as home care services.
9) Provision for bereavement follow-up with the family.

Hospice programs exist in Salt Lake City, Ogden, Tooele, Logan, Brigham City, Provo, Cedar City, Price, and St. George.

Development of a strong relationship with health care professionals in the community is particularly important if continuity of care is to be provided. Hospice teams have demonstrated that through regular visits and communication, institution of pain control and bowel regimen, and training of the patient and family in comfort measures, many clinical and social problems can be prevented or minimized.[3] However, some patients may require intermittent hospitalization; therefore, it is extremely important that the hospice team maintain a close working relationship with institutions and their staffs.

At the time of hospital discharge, the physician refers the patient into a hospice program just as he would into a home health agency. Special orders concerning treatments, dressing changes, pain medications, etc. are received from the physician. The community health nurse, in conjunction with members of the hospice team, and the patient, develop a care plan that is individualized to reflect the patient's and family's wishes.

Often it comes as a surprise to patients, their families and health care professionals that it is possible to provide these services in the home. The patient may be reluctant to request hospice care since he/she fears being a burden on their families, or the prospect of pain. However, at home, the patient is free to determine his own schedule for activities and can remain a participant in family life as long as possible with the assurance of necessary pain control.

The Utah Hospice Organization (UHO) was started in 1980 as a mechanism for communication among agencies and for quality control. the UHO, in conjunction with the Utah Department of Health, is in

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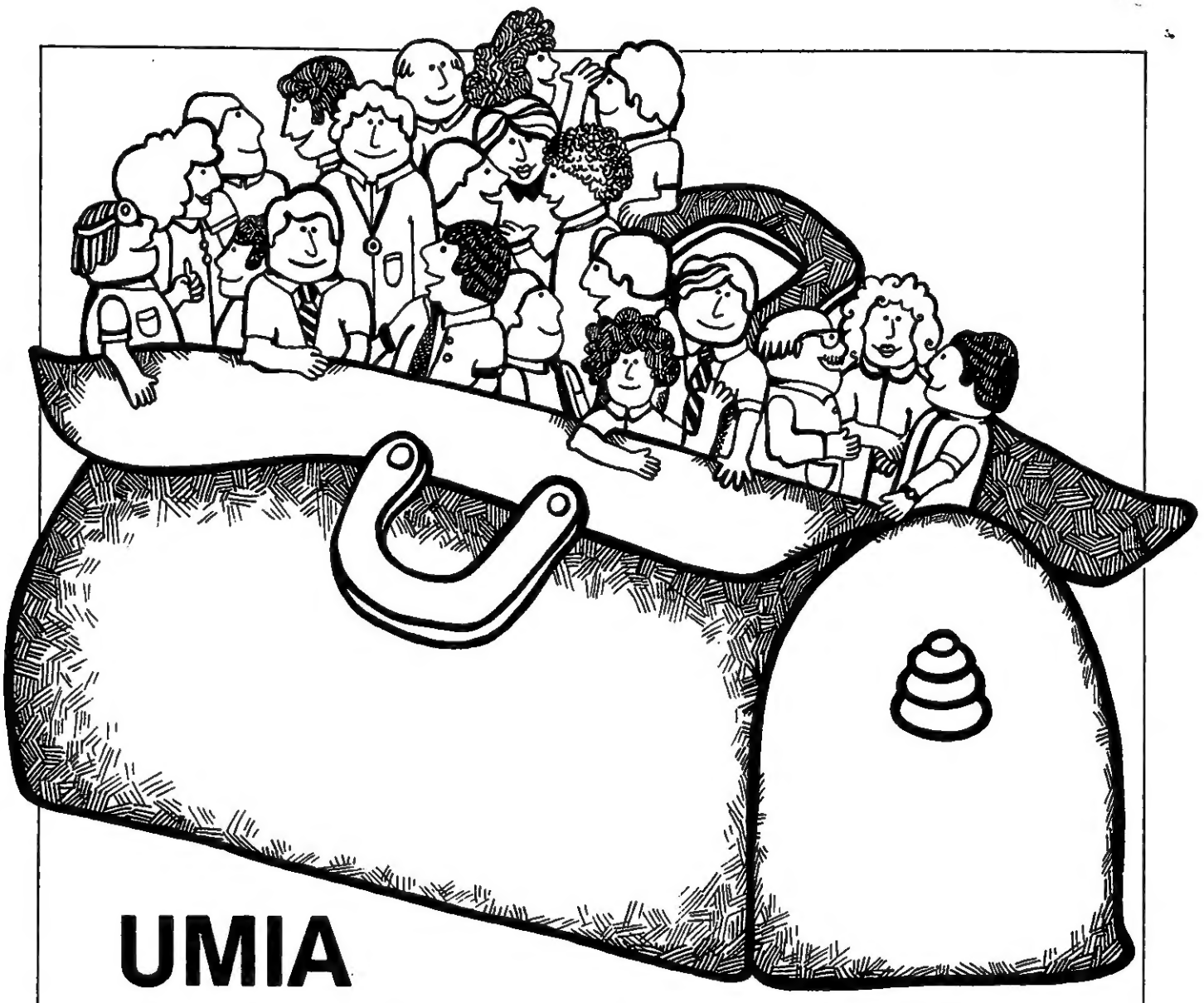

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Hospice *(Continued from page 6)*

the process of accomplishing licensure for all hospices in Utah. This may open new avenues for funding as well as provide standard rules and regulations for each agency.

The Department of Health is currently working on rules and regulations for inpatient hospice services and free standing hospices. The inpatient hospice rules have been submitted to the Health Facility Committee for review. The free standing hospice regulations for licensure should be completed by late 1985.

According to Helen Rollins, R.N., President of UHO, "Our biggest problem is educating the communities in what a hospice can do for the patient and family. Until recently, all of our clients requested to die at home. In the past eight months, we are beginning to see clients who are discharged earlier without being oriented to the home health care concept. They are upset at dying and fear going home. They feel abandoned by the health care system they worked to build."

Although home health care may be a trend of the future, many clients still wish to remain in the hospital and it cannot be assumed that the "Kubler-Ross Philosophy" is for every dying client. Therefore, one challenge for the physician and health care team will be to assist the client with a comfortable and minimally traumatic transition from hospital to home. Ordinarily a primary caretaker such as a spouse or significant other, is needed in the home. However, if this type of person is unavailable, a hospice will coordinate such services for the client.

As health care professionals, we need to re-orient our thinking in relation to the terminally ill patient. To professionals who are masters of diagnostic and treatment skills for purpose of curing, the terminally ill patient may represent a failure. When cure is no longer possible, then care is of foremost importance. Comfort care usually does not require expensive high technology. The major challenges of care for the dying are the alleviation of suffering, support for the patient to remain involved in living and assistance for her or him to die with peace and dignity. The hospice movement is attempting to accept those challenges. In order to succeed, it requires the support of physicians and other health care professionals, community members, and institutions.

"A dying patient is a reminder of our own mortality and is often difficult for us to accept."[4]

1. Stoddard, S.: *The Hospice Movement: A Better Way of Caring for the Dying*, New York, Stein and Day, 1978.
2. National Hospice Organization: *Standards of a Hospice Program of Care*, 6th revision, February, 1979.
3. Ibid.
4. Lattanzi, M.E.: Learning and Caring: Education and Training Concerns: *Dying Persons and Hospice Philosophy*, New York, Springer Publishing Col, 1982, pp 1.

Additional Reference:

Metropolitan Health Planning Council: *Plan for a Hospice System of Care*, Cleveland, Ohio, Stephen R. Connor, 1979.

Staff Leasing Can Be An Asset For Physicians

A growing service for physicians, staff leasing is like hiring a personnel department and frees the professional from personnel managements tasks. It also allows more flexibility in pension plans and fringe benefits.

The "Tax Equity and Fiscal Responsibility Act of 1982" went into effect January 1, 1984. This act makes it possible for professional corporations and small businesses to lease their current employees from a staff leasing company.

Staff leasing can benefit small and medium-sized firms whose owners want to be free of bookkeeping chores and labor problems and take advantage of new tax shelters that are available only if they have no employees except themselves. It also is beneficial for employees who gain better fringe benefits than many small businesses can provide.

Throughout the USA over 20,000 people work for staff leasing corporations whose sales are approaching one billion dollars annually.

Under this new concept the professional employer, corporation, or small business releases all of their current employees. They are then immediately rehired by a staff leasing corporation. They continue to work at their old jobs but are technically employees of the staff leasing corporation. The firm handles the payroll, pays taxes, covers benefits, fills vacancies (if the professional desires), and disciplines employees when necessary. The professional still has control over day to day office operation, makes recommendations on raises, and does final interviews of the job applicants.

Employee leasing companies generally operate on a cost plus basis charging the professional for payroll, taxes and benefit package.

Since January of 1984, professional corporations are not allowed by the Internal Revenue Service to provide higher pensions and fringe benefits for themselves than for their employees. But if the professional is the only employee, they can give themselves favored treatment. Their business can provide them with medical plans, profit sharing plans and tax deductible pension contributions as high as $100,000 per year, while the leasing company provides a smaller yet attractive benefit package to the leased employees. That package must include a yearly pension contribution of 7.5% of each employee's year compensation. Professionals have a tax break, and employees leasing companies can provide benefits like those offered by large corporations because they are purchasing benefits for hundreds of employees.

New Applicants to Salt Lake County Medical Society

Medical Students

Randy F. Thurgood

Physicians

John C. Barkley, M.D.	Anesthesia
Steven C. Dinger, M.D.	Obstetrics & Gynecology
Bruce R. Dooley, M.D.	Emergency Medicine
Jeffrey L. Giese, M.D.	Anesthesia
John L. Gunn, M.D.	Ophthalmology
Douglas R. Hadley, M.D.	Family Practice
David L. Heaston, M.D.	Family Practice
Glenn H. Lubeck, M.D.	Internal Medicine
Lonnie E. Paulos, M.D.	Orthopedic Surgery
Randall J. Stockham, M.D.	Anesthesia
Karen Suprunowicz, M.D.	Emergency Medicine
Laird S. Swensen, M.D.	Orthopedic & Hand Surgery
Paul H. Swensen, M.D.	Pediatrics

New Members of the Utah State Medical Association

Sherman M. Coleman, M.D. Ogden, Utah	Thoracic & Cardiovascular
Douglas P. Felt,M.D. 425 East 5350 South Ogden, Utah 84405	Ophthalmology
Juan D. Fuentes, M.D. 3939 Harrison Blvd. Ogden, Utah 84403	Radiology/ Neuroradiology
David M. Miller, M.D. 55 North Sixth East Price, Utah 84501	Internal Medicine
Steven A. VanNorman, M.D. Dixie Medical Center St. George, Utah 84770	Emergency Medicine/ Internal Medicine
Alton H. Wagonon, Jr., M.D. 4650 Harrison Blvd. Ogden, Utah 84403	Internal Medicine/ Oncology/Hematology
Norman O. Wahlstrom, M.D. 5475 South 500 East Ogden, Utah 84405	Pathology

Physical Examination Review

EXPLANATORY ANSWER:

(C) A left parasternal lift suggests right ventricular enlargement.